# SECTION ONE
# DESCRIPTION OF MENTAL HEALTH SYSTEM

Montana is known as "Big Sky Country" because of its vast size, expansive skies, and rolling plains. The state covers a landmass of 147,029 square miles, has an estimated population of 935,670 (2005), and a population density of 6.2 persons per square mile. To adequately demonstrate the vast size of Montana a map has been included. In 2000, Montana had one of the lowest average annual wages ($24,264) in the nation, yet ranked third in the number of people holding multiple jobs. An estimated 15.5% of the population lives in poverty, including over 20% of our children.


The population of Montana is predominately Caucasian (91%). The principal minority group in Montana is American Indian (6.2%). Included within the boundaries of Montana are seven Indian reservations. Each is a distinct and sovereign nation, with a government, culture, and health systems that must be independently engaged and consulted. Poverty on the reservation is extreme, ranging from a low of 20% on the Flathead Reservation to a high of 39% on Fort Belknap. Unemployment rates range from 44% to 55%. The Indian Health Service provides

behavioral and medical services for tribal members at 13 sites throughout Montana, both on the reservations and in the urban locations of Billings, Helena, Great Falls, and Butte. Other minority populations include Hispanic (2%), Asian or Pacific Islander (.6%), and African American (.3%). 28.6% of the population is under the age of 20.

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for public mental health system. The adult and children's system have separate administrative structures within DPHHS. The adult mental health system is administered through the Addictive and Mental Disorders Division. This division also administers three state-run facilities: the Montana State Hospital, the Montana Mental Health Nursing Care Center, and the Montana Chemical Dependency Center. The Health Resources Division administers children's services through the Children's Mental Health Bureau. In addition, HRD is responsible for Medicaid Primary Care services, and the Children's Health Insurance Program (CHIP).

Medicaid mental health services are provided to adults with severe disabling mental illness (SDMI) through a fee for service system that includes five licensed mental health centers, an estimated 550 private practitioners, 50 psychiatrists, other physicians, and four community hospitals with inpatient psychiatric beds. The state also administers the Mental Health Services Plan (MHSP) for adults with SDMI who are not eligible for Medicaid and have a family income that does not exceed 150% of the federal poverty level. MHSP services are contracted to four community mental health centers, and beneficiaries receive a limited pharmacy benefit of $425 per month toward the cost of psychotropic medications.

The Children Mental Health Bureau (CMHB) is responsible for management of children's mental health services and development of a system of care for youth mental health services. The mental health services have several funding sources: Medicaid, Children's Health Insurance Plan (CHIP) and the Children's Mental Health Service Plan (CMHSP).Youth with serious emotional disturbance can access services by one of these plans. Each program has eligibility criteria and limits to their service array.

Separate administration and budgets don't preclude the adult and children's mental health systems from working together, collaborating, and ensuring quality public mental health services. Staff, administrators, parents, and consumers cross-over in meetings, services, and training in efforts to provide adequate services to those in Montana with serious mental illness. At the state level, the Mental Health Oversight Advisory Council (MHOAC) has representatives from the Children's mental health system, and likewise, the System of Care Committee (SOC) has representatives of the adult mental health system. At the regional and local levels the same is true.

During the 2005 Legislative session the Montana Legislature changed the Medicaid eligibility resource test. The projected increase to Medicaid is 3800 youth, with 3000 moving from the

Children's Health Insurance Program (CHIP) to Medicaid. With last year's increase in the number of available slots, CHIP has a capacity to enroll 13,900 youth. Current enrollment is 13,113. Although CHIP remains a capped service, providing a limited number of slots, this increase eliminated the entire CHIP waiting list. CMHSP income guidelines are set at 150% of poverty. One-hundred thirty-five youth are eligible for CMHSP- Part A if they are not eligible for Medicaid or CHIP.

Montana currently has four community mental health centers that provide outpatient services in fifty-five of fifty six counties. In addition to these community mental health centers, Montana has thirteen licensed mental health centers that serve youth and provide each of the core services as well as one or more of the services typically provided by a community mental health center. The Department contracts with six agencies to provide targeted youth case management. The providers are required to provide case management in identified service delivery areas.

The principle challenge to developing and maintaining human services programs in Montana is accessibility. Although concentrating services in larger areas would be the most efficient strategy for delivery, Montana has maintained an effort to provide mental health services in every county in the State. This accessibility provides for, at a minimum, identification of serious mental health problems, referral to more specialized services in larger communities, and supportive therapy and case management.

Because of the extreme rural nature of Montana, our entire plan is essentially a plan for delivery of mental health services in rural settings. For this reason, as will be further explained in "Descriptive Information" under ***Criterion 4,*** we have not identified specific objectives relating to rural issues. The entire plan addresses the manner in which mental health services will be provided to individuals residing in rural areas.

<u>Mental Health Oversight Advisory Council</u>

The Mental Health Oversight Advisory Council (MHOAC) has provided valuable input to the Department over the past year. The mission of the Council is "Partners in planning for recovery based mental health system throughout Montana." The purpose of the Council as defined in state law (53-21-701(6)(a-d) is to:

- Provide input to the department in the development and management of any public mental health system.
- Provide a summary of each meeting and a copy of any recommendations made to the Department to the Legislative Finance committee and any other designated appropriate legislative interim committee.
- Fulfill any federal advisory council requirements in order to obtain federal funds for this program.

In addition, the Mental Health Oversight Advisory Committee has established the following

guiding principles:

- Recovery and resilience
- Equity, access and satisfaction
- Cultural competence
- Community-based solutions
- Community education and awareness
- Flexibility
- Diversion
- Address co-occurring disorders
- Fiscal responsibility

The Mental Health Oversight Advisory Council received technical assistance from the National Association of Planning and Advisory Councils. The Council expressed interest in expanding the Council representation to include Kids Management Authorities (KMA) and Service Area Authorities (SAA). In addition, the Council agreed to focus on three goals for the coming year. They are: establishment of local crisis services; to facilitate a better transition of inmates from the state prison who have a mental illness; and expansion of peer support services. The Council also held a work session to discuss the block grant and the new bylaws. This work session proved to be very productive for HRD, MENTAL HEALTH SERVICES BUREAU (MHSB) and the Council.

In 2005 MHOAC and MHSB determined to meet the intent of the federal and state statute MHOAC needed to be expanded from 21 members to 30 members. The request for expansion of the MHOAC membership was sent to the Director of the Department and the Governor. Request for MHOAC members was advertised in all the major daily newspapers, sent out to SAA, Local Advisory Councils (LAC), and KMA, put on the Department and Governor's web sites, and sent to all advocates. The Governor's staff appointed the new members the end of July 2005 and the first meeting of the new Council was held in August 2005.

Children's System of Care

Since 2003 the Children's System of Care has provided statewide leadership in the emerging development of a community-based, youth and family-centered, culturally competent mental health system. Core values guiding this system include:

- Parent/Family participation at all levels of the children's system of care from policy planning to participation in their child's treatment plan.
- Cultural competence requiring agencies, programs and services to be responsive to the needs and culture of the populations served.
- A focus on the strengths of the parents and family as contributors to treatment and recovery.
- "Top-Down-Bottom Up approach" in partnerships with local communities, including our seven sovereign nations to design and develop the system of care.

- Through partnerships with providers design, and deliver evidenced-based services to youth with SED and their families.
- Increase co-occurring capacity to ensure service delivery with an integrated focus on both mental health and chemical dependency treatment needs.

Service Area Authorities

Service Area Authorities are intended to exercise local control of the public mental health system by stakeholders. Emphasis is placed on achieving better consumer outcomes, increased performance by service providers, and more cost-effective delivery patterns and processes. By dividing the state into three separate regions, communities within each region can better manage a system that meets the unique needs of the area.

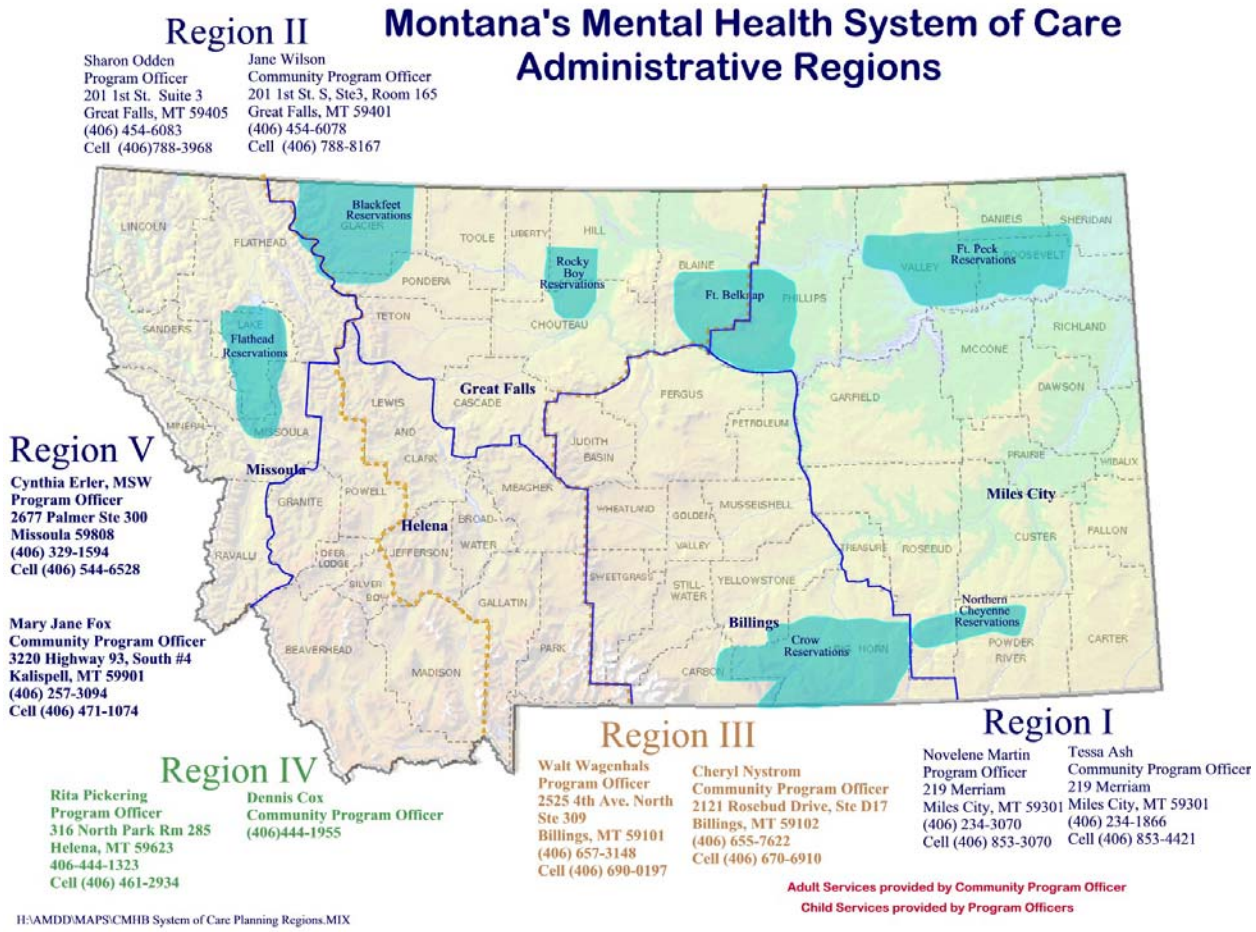
Restructuring the public mental health system in Montana has been no small task. Each SAA has obtained nonprofit corporation status and have leadership boards. The boards are 51% consumer and family member representation. The SAA and LAC development has taken over five years. The Department is requesting the SAA and LAC to actively participate in the development of the crisis response plan for Montana.

Kids Management Authorities

The Kids Management Authority provides a framework for parents, youth, and agencies to participate in the development of comprehensive plans of care for children at risk of out-of-home placement. These include the education, vocational rehabilitation, state approved alcohol and drug programs, juvenile justice, housing, and First Health regional care coordinators. This is to ensure that needed services are available for the adolescent and his/her family.
KMAs have two distinct and important functions:

- **Community Teams**
  They are tasked with creating a process for a local system of care, identifying and creating ongoing community resources, developing policies and procedures to ensure unified and comprehensive service delivery, and serving as the gateway to the local system.
- **Individual Care Coordination Teams (ICCT)**
  With few exceptions, parents are the leaders of the individual team for their child. The team, comprised agencies and individuals involved with the youth and their family design a unified and comprehensive treatment plan that encompasses all agencies serving an individual family.

Below is the map of the administrative regions and the program officers for the children mental health and adult mental health system.




New Initiatives

The Children's System of Care Committee (SOC) ushered in a new approach to the delivery of services to youth with SED and their families. Created by the 2003 Legislature this advisory group continues to grow in its capacity to manage the emerging system of care, and provide leadership to local communities as Montana moves towards family and youth driven, community based mental health services. This new approach is guided by system values that include:

- Parent/Family participation is to be a part of all levels of the children's system of care from policy planning to participation in their child's treatment plan.
- The system is culturally competent requiring agencies, programs and services to be responsive to the needs and culture of the populations served.
- Providers, planning, policies, etc. focus on the strengths of the parents and family as contributors to treatment and recovery.
- "Top-Down-Bottom Up" approach in partnerships with local communities,

including Tribes to design and develop the system of care.

- The system through partnerships with providers designs and delivers evidenced-based services to youth with SED and their families.
- Services for youth with SED will be co-occurring capable to ensure service delivery with an integrated focus on both mental health and chemical dependency treatment needs.

Representatives from the following entities comprise the Committee: Parents and Youth; Providers; Native Americans; Supreme Court (juvenile probation); Office of Public Instruction; Legislature; Mental Health Advocates/Ombudsman; Department of Corrections; Service Area Authority (SAA); Mental Health Oversight Advisory Council; Department of Public Health and Human Services (Children's Mental Health Bureau. Chemical Dependency Program, Child and Family Services Division Disability Services Program); and First Health Services of Montana.

The Department of Public Health and Human Services enters its third year of a six year SAMHSA System of Care grant October 1, 2006. The first community grants were awarded in October 2005 to Billings, Missoula and the Crow Nation, our SAMHSA partner. These sites are ending their first year of infrastructure development and moving into year two will begin to offer services to youth and their families. Three additional communities were chosen in the second round of implementation grants in August 2006 -- Helena, Butte, and a northern Montana collaboration between the Fort Belknap Reservation, the Rocky Boy's Reservation and Hill County.

The major initiatives for the MHSB are: designing a crisis response system; the SSI/SSDI outreach, access, and recovery (SOAR) training; co-occurring initiative; strengths based case management; housing projects; shelter plus care vouchers; Dilalectical Behavioral Therapy (DBT) and Assertive Community Teams (ACT) are stronger and more effective; pursuing a Health Insurance Flexibility and Accountability (HIFA) and Home and Community Based Waivers; strengthening the relationship with the SAAs and the division; developing peer support services; and utilizing the field staff.

The philosophy of the adult mental health system is to provide a system that is person centered and the focus of all services provided to the individual. All services available have the goal of recovery.

The philosophy of the children's public mental health system is to provide services that respect the preferences and rights of youth and family members as well as accommodate the special needs and circumstances of both. Montana's public mental health system strives to provide a full range of mental health services to children and adolescents with priority on services to youth with serious emotional disturbance. To the greatest extent possible, services are offered in the

least restrictive, most appropriate, community-based setting, preferably in the adolescent or child's home

# SECTION TWO
## IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS AND PRIORITIES

### Strengths and Weaknesses

The primary weaknesses of the public mental health system in Montana as identified by the Mental Health Oversight Advisory Council and Mental Health Services Bureau can be categorized as follows: crisis services; medically indigent services; access to services; children issues; peer support and services; criminal justice issues; education of mental illness; homelessness; housing; employment; suicide prevention; elderly; admission criteria to the Montana State Hospital; transition services; and cultural competence.

The Children's System of Care Committee identifies the following for Seriously Emotional Disturbed (SED) youth and families: a lack of clearly defined mechanisms for parental involvement, systems that fail to recognize and respond to early danger signs, inconsistent availability of community-based services, fragmented services, deficit-based views and a lack of cultural understanding.

Crisis Services

Montana has the highest suicide rates in the nation for youth between 10 to 14 of age and second for those persons between the age of 15 to 34. Montana currently has some components of a crisis response system, crisis telephone lines, mobile teams in some parts of the state and some crisis houses available to individuals who voluntarily agree to stay. All licensed mental health centers must provide twenty-four hour access to their services. Many communities have mental health professionals available to do assessments.

Only four communities in Montana provide inpatient psychiatric services. The closest facility in Eastern Montana is Billings so a person in crisis in Scobey, MT must travel 370 miles (or about six hours in good weather) to the nearest available inpatient psychiatric facility. By default, general hospital emergency rooms provide the entry point for those in mental health crisis (adult and youth) requiring mental health crisis services.

Services are not consistent across the state and all crisis stabilization services lack secure rooms. In many cases there are no secure facilities. Often the result is individuals with mental illness are sent to the Montana State Hospital prior to a commitment hearing because the person is a danger to self or others and therefore, must be maintained in a secure setting. Fifty percent of the admissions to the state hospital are emergency detentions and involuntary commitments.

Crisis for SED youth takes on a different aspect than for adults. While the youth may be unstable emotionally, the inability of their parent, family or community to manage their symptoms can precipitate a crisis which requires higher levels of care. Increased access to respite services and crisis stabilization services inside the home are preferable to hospitalization. Over 85% of the acute hospitalizations for youth result in discharge to higher levels of care, most often residential treatment.

The 2005 Legislative session allocated $875, 000 for developing community crisis planning. Following are the project summaries funded July 2006. These are one time funds. Following are the grant summaries awarded:

- Eastern Montana Community Mental Health Center **$65,000**
  EMCMHC requested funding for three components in its proposal: (1) purchase of an additional portable teleconferencing monitor to expand its capacity to participate in teleconferences with mental health offices and facilities throughout the eastern region; (2) funding for a pilot project that would establish a 30-day eligibility for individuals who are at imminent risk to self or others by suicidal or homicidal ideations; and (3) supplemental funding for crisis response for MHSP beneficiaries.

- Center for Mental Health Center **$163,908**
  Center for Mental Health proposed to administer a recovery-oriented Crisis Peer Support Pilot Project that will utilize nationally-recognized experts to assist in the development of Medicaid-reimbursable crisis peer support services. The grant will provide funding for a Program Director, support staff, peer training subcontractors, and travel and training expenses. Pilot will be implemented in both urban and rural settings.

- Rocky Mountain Development Council - Helena **$207,984**
  Proposal for creation of a tri-county mental health crisis response partnership with funding oversight responsibilities shared by Lewis & Clark, Jefferson, and Broadwater counties. The grant will support a project director, operation of a non-secure crisis stabilization facility by Center for Mental Health CMHC, and creation of a mobile crisis response team to provide 24/7 professional mental health assistance throughout the tri-county area.

- South Central Community Mental Health Center- Billings **$139,700**
  Proposal for purchase and installation of Pathways Compass® case management system in ten rural hospitals in the Eastern Service Area Authority; provide regional WRAP training; and provide regional crisis intervention team (CIT) training for law enforcement personnel.

- Western Montana Community Mental Health Center – Butte **$231,126**
  Proposal for development of a peer-to-peer consumer recovery and support system and

for assistance with funding for the building of a non-medical crisis stabilization facility in Butte. The facility will include a total of 12 beds, with the capacity for 4 of those beds to be locked and to detain people involuntarily if so ordered by the court. It will also include the capacity to use 2 beds for detoxification and 6 beds for voluntary crisis stabilization.

- Western Montana Community Mental Health Center – Hamilton **$67,300**
  The proposal seeks to plan, develop and construct a crisis center providing 4 beds for community residential crisis stabilization and/or detox services and an additional four transitional beds for persons needing longer term stabilization. Grant will support a project coordinator, travel and office expenses, and architectural fees. The grant will also support WRAP training for consumers in Ravalli and western Beaverhead counties.

Transition Services

The transition of moving a youth with a serious emotional disturbance into the adult mental health system is difficult. The Transition Work Group consists of state level personnel from Developmental Disabilities Division, Adult Mental Health, Child and Family services, First Health Inc., of Montana, Early Head Start Collaboration, Court Services, Department of Corrections, and Tribal Nations. The Transition Work Group is tasked with developing smoother transitions from the various system of care.

The HIFA waiver, if approved, would have slots for those SED youth that will not qualify for adult mental health services. Those youth would obtain transition services until the age of 21. Currently, SED youth who "age out" of the system find themselves unprepared for adulthood often homeless. The shelters in Billings, Great Falls and Helena have identified a group of young adults that migrate from one shelter to another.

Social Security

The time lapse between application for Social Security Insurance (SSI) or Social Security with Disability (SSDI) is long and arduous. While applications are pending. applicants and their families cannot access critical components for recovery: medication and housing . Or worse, they give up on the process and access services only when in severe crisis.

Montana was selected to be one of the fourteen states and/or cities for the SOAR project. SOAR is the acronym for SSI/SSDI Outreach, Access and Recovery. This has proven to be a highly effective training for case managers who are working with persons who are homeless and have a mental illness. Yvonne Perrette, a nationally recognized expert, piloted this project in Baltimore. The trainers for Montana are Michelle Thibodeau, Disability Determination Services; Sherrie Downing, Governor's Council on Homelessness; and Marcia Armstrong, Addictive and Mental Disorders Division. The project will be collecting and reporting on outcome data which will

assess the effectiveness of Montana's plan to increase access to disability benefits.

Lack of Psychiatrists

One major need in Montana's public mental health system is access to psychiatric services. Distance to psychiatrists, availability of child psychiatrists, and psychiatric services available in communities and not institutions create huge issues. Waiting lists for appointments, medication reviews, not to mention those in crisis, increase the potential for hospital admission. This creates a "management by crisis" system rather than one focused on recovery.

Advanced Practice Registered Nurse (APRN) who have prescription authority are part of the solution to this management crisis. Some mental health centers rely on APRNs; others refuse to use them at all relying totally on their psychiatric staff. Other mental health centers have paid for their RN staff to get their advanced degree.

Peer Support Services

Another gap is the lack of peer support services. Mental health centers employ consumers in supportive employment, but Montana does not have consumer run services in Montana. This will be a priority in the next two years to develop peer run services and a method for reimbursement for the services. The Assertive Community Treatment (ACT) teams are investigating the possibility of including peer specialists on the team. The Mental Health Oversight Advisory Council has received technical assistance on models from South Carolina and Georgia for peer services.

As one consumer so aptly said, "We need more programs for peer mentoring and support for independent living. When I am doing things for other people who are having trouble, my troubles don't seem to be so bad. I might be able to help myself while I am helping someone else."

The children's system has no formal mechanism for youth and/or parents to offer support to one another. Having parents as part of the KMA community team adds a personal dimension otherwise missing from the conversation. Parents' ability to empathize, support, as well as confront others in similar situations is incredibly powerful. As the KMA and SOC models grow, this component has the potential to be the strong link in the system chain.

System Issues

The gaps noted in Montana's children systems of care continuum include: stigma of being a person with and/or raising a youth with a mental illness, a real commitment for youth and parental involvement in planning for individual services and policy and planning, lack of prevention and early intervention services, a serious lack of child psychiatrists across the state

that are available for publicly-funded youth, lack of adequate community based services and payment mechanisms for those services families find most useful, services that are duplicative and not coordinated, deficit-based rather than strength-based services, disparity in culturally sensitive services.

The adult mental health system has identified the following as major issues: lack of crisis response system; inadequate accurate and complete data from providers; lack of coordination with the Native American population and reservations; inadequate number of mental health personnel; community based capacity of services; disparity in culturally appropriate services; and increasing number of persons with mental illness who are in the correctional system.

Strengths

The greatest strength of Montana's public mental health system are those involved in it- most important are those individuals with severe disability mental illness, youth with serious emotional disturbance and their families. Providers, Mental Health Oversight Advisory Council, Systems of Care Grant and Committee, the relationship with NAMI-MT and Mental Health Association of Montana add a strong professional component to this system development. The strength of these relationships and the resolve to makes things better, is the driving force in Montana's system evolution.

MHSB has had standing cooperative agreements at the state level with the Montana Vocational Rehabilitation (MVR) Services Programs that outline their commitment to both supported and transitional employment programs since the inception of supported employment in Montana. While these agreements have served to define terms of service, and provide general guidance regarding the execution of employment services, both MHSB and MVR are committed to strengthening these relationships and increasing the incidence of successful, meaningful employment outcomes for persons with mental illness. To that end the agencies will strengthen service provision in Montana by providing technical assistance to local service communities for the purpose of developing local Cooperative Agreements that reflect a commitment to building stable, sustainable return to work programs utilizing the coordinated assets of MHSB and MVR.

Many people have been working in the mental health field for twenty or more years. Relationships have been forged and partnerships have been developed. The dedication and resourcefulness of Montana's providers is a resource that will ensure Montana continues moving in transformation of its mental health service system. This transformation will bring service provision more directly in alignment with the New Freedom Commission recommendations.

The DPHHS has taken the New Freedom Commission Report to heart. Given this direction, the mental health system in Montana has begun evolving and developing the necessary tools for a recovery and consumer centered system. Montana has a long journey ahead but with the commitment of the stakeholders, providers, consumers and family members; transformation

effort of the public mental health system will succeed.